



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH

LANSING

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GOVERNOR

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DIRECTOR

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Dear Hospital Provider and Medicaid Health Plan Provider:

The purpose of this letter is to provide clarification of 15-day readmission policy for beneficiaries enrolled in Medicaid Health Plans. The Michigan Medicaid Provider Manual describes Medicaid policy regarding hospital readmissions. The reimbursement for a readmission is dependent on whether the second admission is related to the first admission. Specifically, Section 2.8.G of the Hospital Chapter – Hospital Reimbursement Appendix in the Provider Manual states the following:

2.8.G. READMISSIONS

Readmissions within 15 days for a related condition, whether to the same or a different hospital, are considered a part of a single case/episode for payment purposes. If the readmission is to a different hospital, full payment is made to the second hospital. The first hospital's payment is reduced by the amount paid to the second hospital. The first hospital's payment is never less than zero for the episode. Readmissions within 15 days for unrelated conditions, whether to the same or a different hospital, are considered new admissions for payment purposes.

The policy's intent is to reduce hospitals' incentives to prematurely discharge a patient that may lead to a subsequent readmission. However, different interpretations of this policy by hospitals and by Medicaid Health Plans have created barriers to timely and accurate payment for both the hospitals and the Medicaid Health Plans. In an effort to resolve these barriers, the Michigan Department of Community Health (MDCH) convened a workgroup with representatives from the hospital industry and from the Medicaid Health Plans to clarify the policy's intent and define circumstances in which admissions were to be considered separate or combined for payment purposes.

The workgroup formulated a set of readmission guidelines that hospitals and Medicaid Health Plans could utilize in determining whether a readmission should be treated as a separate admission or a combined admission for payment purposes. The attached guidelines and suggested discharge planning elements provide further clarification of the policy specified in the Provider Manual; **the guidelines do not replace or revise the existing 15-day readmission policy.** It is not possible to anticipate and define all possible circumstances surrounding readmissions; further clarification may be needed from time to time to define additional circumstances related to readmissions.

If you have questions regarding this policy clarification, please contact Cheryl Bupp at (517) 241-7933. Thank you for your continued participation in the Michigan Medicaid program and your commitment to providing quality care to Michigan's most vulnerable citizens.

Sincerely,

Paul Reinhart, Director
Medical Services Administration

attachments

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GUIDELINES FOR HOSPITAL READMISSIONS WITHIN 15 DAYS

The Michigan Department of Community Health (MDCH) convened a workgroup with representatives from the hospital industry and from the Medicaid Health Plans (MHPs) to formulate a set of readmission guidelines that hospitals and MHPs could utilize in determining whether a readmission should be treated as a separate admission or as a combined admission for payment purposes. The following Readmission Guidelines: 1) provide further clarification of the policy specified in the Michigan Medicaid Provider Manual; 2) do not replace or revise the existing policy; 3) do not alter any MHP policies or prior authorization requirements; and 4) are intended to be a general framework to facilitate hospitals and MHPs reaching consensus about the appropriate reimbursement for readmissions. It is not possible to anticipate and define all possible circumstances surrounding readmissions.

The Readmission Guidelines and the Discharge Planning Guidelines (attached) are best used in conjunction with each other. In the Readmission Guidelines, the discharge plan plays a key role in the determination of whether any subsequent readmission should be treated as a separate episode or combined with the previous admission for payment purposes.

Definitions

- **Category:** There are two types of categories: S1 through S4 (separate), and C1 through C6 (combined). Categories that begin with an “S” denote those readmissions that the hospital may bill as separate admission; the MHP will reimburse the hospital for two separate admissions. Categories that begin with a “C” denote readmissions that should be combined with the first admission; MHPs will reimburse the hospital for a single combined admission.
- **Description:** Brief explanation of the type of readmission. The descriptions are intended to be general to allow the hospitals and MHPs to utilize these guidelines across most situations.
- **Billing:** Denotes type of billing/reimbursement category: Separate or Combined
- **Appeal Rights:** Denotes hospital’s ability to *appropriately* utilize the MHP’s provider appeal mechanism.
- **Comments:** Additional information and examples to help the hospital and MHP determine which category applies to the readmission.

Financial Recovery and Appeals

The Readmission Guidelines address financial recovery and appeals based solely on 15-day readmissions. It does not address recovery or appeals that may be appropriate for any other purposes (i.e., other insurance, eligibility).

- **Categories S1 – S4:** Financial recovery based on 15-day readmission criteria is not appropriate since both admissions are to be treated as separate episodes for payment purposes.
- **Categories C1 - C6:** If a hospital bills both admissions as separate admissions, the guidelines allow the MHP to conduct an audit adjustment to combine the admissions. The MHP must follow contractual and Medicaid policy regarding the appropriate DRG to pay for the combined admission.

Financial recovery based on 15-day readmission criteria is likely to occur. If the hospital has already been paid for the first admission, the guidelines allow the MHP to recover payment made for that admission. The nature and timing of the financial recovery is usually addressed in contracts or agreements between the hospital and the MHP. However, some general guidelines are offered:

- If the combined billing status is determined before the second admission is billed, the MHP may recover the payment made for the first admission and notify the hospital to combine the claim for both admissions.

- If the combined billing status is determined after the second admission has been billed and paid separately, the MHP will notify the hospital that the MHP intends to recover payment unless the hospital files an appeal with the MHP. The MHP must send the notice of intent to recover within 12 months of the date of service. If the contract between the hospital and the MHP allows fewer than 12 months for the hospital to bill, then the MHP must also comply with this shortened time frame for notifying the hospital of the MHP’s intent to recover. The appeal should include all documentation specified in the Readmission Guidelines or requested by the MHP in the notification letter.
- If the hospital and the MHP cannot reach agreement through the MHP appeal process, the hospital and the MHP may utilize the rapid dispute resolution process outlined in the Hospital Access Agreement or arbitration as outlined in the MHP contract.

Readmission to Different Hospitals

For “Bill As Combined” readmissions to different hospitals, hospitals are unable to combine their admissions for payment purposes. Some general guidelines are provided for these circumstances:

- The MHP provides written notification to the first hospital of the “Bill As Combined” status within 30 days of the first admission’s discharge date.
- The written notification should include, at minimum, the following information: Patient Name, Patient ID, first admission dates of service, combined status reason (C1 – C6), and admission date of second admission.
- The notification should cite Michigan Medical Provider Manual – Hospital Reimbursement Appendix, Special Circumstances Under DRG Reimbursement section, as the Medicaid policy and procedure applicable to the case/episode.
- The first hospital has the right to appeal the payment decision utilizing the MHP’s provider claims appeal mechanism or the MDCH Rapid Dispute Resolution process for claims disputes.

Readmission Guidelines

Bill as separate admissions . . .				
Category	Description	Billing	Appeal Rights	Comments
S1	Member is readmitted within 15 days for unrelated conditions.	Separate	NA	The documentation should indicate that the readmission does not meet any of the criteria for a combined admission. <i>Example: Admission 1 for gall bladder removal. Admission 2 for multiple injuries due to home accident.</i>
S2	Member meets discharge criteria and has an appropriate discharge plan, but requires readmission due to a new occurrence of same condition or due to a direct or related complication from surgery. All standards of care were met. Patient was stable at discharge. Health plan participated in discharge plan of first admission (preferred).	Separate	NA	Documentation must include a discharge plan that is appropriate and reasonable. Discharge plans should include the member’s ability to follow the treatment plan after discharge. Lack of health plan participation in discharge plan may create delay in determination for separate billing status. <i>Example: Admission 1 for sickle cell with pain crisis, appropriate discharge plan, and meets criteria. Admission 2 for sickle cell with pain crisis.</i>

Bill as separate admissions . . .				
Category	Description	Billing	Appeal Rights	Comments
S3	Member fails to follow the discharge plan of the first admission (non-compliant).	Separate	NA	Documentation for the second admission must include that member <u>reported</u> non-compliance of first admission's discharge plan. <i>Example: Member did not get prescriptions filled.</i>
S4	Member leaves against medical advice and requires subsequent readmission.	Separate	NA	The documentation should show that the member signed out against medical advice. The documentation must further demonstrate the hospital's attempt to educate member regarding possible complications due to non-compliance with care plan and likelihood of readmission.

Bill as combined admissions . . .				
Category	Category	Category	Category	Category
C1	Member is discharged before all medical treatment is rendered. Care during the second admission should have occurred during the first admission.	Combine admissions as continuation of care	Yes; if documentation supports that the patient's condition was recognized and it was appropriately determined the treated condition did not require follow-up, or that appropriate outpatient follow-up arrangements are documented.	<p><i>Example: Member is treated for pneumonia, responds, and meets discharge criteria. However, a fecal occult blood test is positive -- Hgb 10.9 grams. The hospital record does not support that this was recognized, and appropriately determined not to require investigation during the first admission. No follow-up of the fecal occult blood test is documented. The member is readmitted five days later with gastrointestinal bleeding. Combine the admissions as continuation of care.</i></p> <p><i>Example: Member is treated for pneumonia, responds, and meets discharge criteria. However, other lab tests performed during the initial admission are abnormal. The member is readmitted for a condition related to abnormal lab tests. No follow-up on the abnormal lab test is documented in the patient record for the first admission.</i></p> <p><i>Example: Member is treated for dehydration secondary to persistent emesis and responds. Member is discharged on a medication for outpatient use different than that used during inpatient care. Member is readmitted because the outpatient prescribed medication did not work.</i></p>
C2	Member is discharged without discharge criteria being met, including the clinical and level of care criteria.	Combine admissions as premature discharge.	Yes; if hospital is able to provide documentation indicating the member was stable at discharge.	Clinical review supports that the member was prematurely discharged.

Bill as combined admissions . . .				
Category	Category	Category	Category	Category
C3	Member is discharged from the hospital after surgery, but is readmitted within 15 days. The standards of care for evaluating the patient for known complications are not documented in the record. The readmission is due to a direct or related complication from the surgery.	Combine admissions as continuation of care.	Yes	<p>The monitoring, evaluation and treatment of the member for known sequela or common complications following surgery is not documented in the record and/or is not addressed in the patient's discharge plan.</p> <p><i>Example: An open appendectomy is performed, and the member is discharged on the second post-operative day without evaluation for known complications during the hospital stay or arranged as part of the discharge plan. The member returns in three to five days with a wound infection requiring hospitalization and further treatment for a condition that should have been checked during the first admission or through follow-up arranged by the hospital. The admissions are combined as the DRG for an appendectomy.</i></p>
C4	Member discharged from the hospital with a documented plan to readmit within 15 days for additional services. (doctor requested, member requested)	Combined as planned readmission	Yes	<p>The care rendered during the subsequent admission was anticipated.</p> <p><i>Examples: A discharge from hospital for physician convenience (surgeon away/operating room booked), member convenience, member needs to return home or requests time to make a major health care decision.</i></p>
C5	Member is discharged to allow resolution of a medical problem that, unless resolved, is a contraindication to the medically necessary care that will be provided during the second admission.	Combined as planned readmission	Yes; if the hospital clearly documented the medical necessity for the interruption of care based on issues such as the specific co-morbidity and the stabilization of the member.	<p><i>Example: Discharge to await normalization of clotting times prior to a surgical intervention.</i></p>
C6	Member is discharged meeting discharge criteria but non-clinical factors have not been addressed, and member has had previous 15-day admits. Member has issues or barriers that require discharge plans beyond the typical.	Combined as inadequate discharge plan	Yes; if hospital is able to document discharge plan addressed, and non-clinical contribution to re-admission were addressed.	<p><i>Example: Sickle cell with pneumonia and evidence of pneumonia on prior admission. No evidence that non-clinical factors that contribute to member's ability to comply with treatment plan were addressed (i.e., member is discharged home, but is homeless).</i></p>

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
DISCHARGE PLANNING GUIDELINES

The following elements are **suggested** as part of a comprehensive discharge plan. Discharge planning plays an integral role in the determination of whether any subsequent readmission should be treated as a separate episode or combined with the previous admission for payment purposes. Medicaid Health Plan (MHP) and hospital discharge planners are encouraged to work collaboratively to include elements or areas in which the discharge plan is likely to fail and make sure there is an intervention to address that likelihood. In the event of weekend and evening discharges when it may not be possible for the MHP and hospital to coordinate the discharge plan, it is recommended that the MHP and the hospital discuss the discharge plan on the next business day.

Contacts

- Name and contact number for Hospital Discharge Planner
- Name and contact number for MHP Discharge Planner
- Appropriate authorizations have been obtained

Primary Language

- Member or caregiver(s) received instructions in language of choice
- Attempts to get member connected with provider(s) that speak language of choice
- Interpreter involved as necessary

Social Support Referral

- Name of Social Worker (if different than above)
- Member's Social Support System
- Member's Home/Living Environment
- Alternatives/Plan
- Note why an Alternative Living Arrangement may not be possible
- Referral to CSHCS, if appropriate

Case Management – MHP Responsibility

- Referred to [Name of Organization]
- Referred to MHP case management
- Document communications
- Document request for in-hospital visit vs. post-discharge follow-up

Follow-Up Appointments

- Appointment to be made by Member/Family Member/MHP Customer Services
- Name of person/relationship of party responsible for follow-up
- Referred to MHP Member Services for appointment and/or transportation – Date and time of appointment/transportation arrangement
- Documentation of member's understanding by either MHP or facility

Pharmacy

- Hospital or physician to work with MHP and MHP's Pharmacy Benefits Manager (PBM) to obtain appropriate authorization
- Member has medications and/or prescriptions that require prior authorization (PA)
- All medications and/or prescriptions requiring PA have been sent to pharmacy/pharmacy benefits manager according to MHP policy
- Member has medications and/or prescriptions
- MHP may call to verify that the member has medications and/or prescriptions

Home Health Care/Infusions/DME

- Evidence that service was ordered or not ordered (reason)
- Name of agency/company
- Services/equipment ordered
- Infusion – access type and drug ordered
- Evidence that services/equipment were delivered – Follow-up by MHP
- Confirmed that member has understanding of services/equipment – follow-up by MHP

SNF

- Facility Name
- Estimated length of stay (example: greater than 45 days)
- Services to be provided by SNF
- Transfer occurred

Sub-Acute Care

- Facility Name
- Estimated length of stay (example: greater than 45 days)
- Services to be provided by sub-acute facility. NOTE: "Sub-acute care" refers to a level of care not recognized by Michigan Medicaid; MHP and facility must arrange appropriate reimbursement.
- Date transfer occurred

Acute Rehab

- Appropriate approval by MHP obtained
- Name of facility
- Estimated length of stay (example: greater than 45 days)
- Services to be provided at facility
- Date transfer occurred

Hospice

- Candidate for Hospice?
- Evaluation for Hospice?
- Appropriate; offered to member; member refusal?
- Document if member refused
- Type of hospice setting/name of provider

Mental Health/Substance Abuse

- Referral to Provider
- MHP approved
- MHP or CMH Program responsibility
- Appointment confirmed – MHP to schedule appointment
- Name of provider or agency

Diabetic

- Hemoglobin A1C Result to MHP, if available
- Glucometer in home confirmed or ordered – MHP follow-up
- Strips in home confirmed or ordered – MHP follow-up
- Diabetic Education – Referral by MHP – Name of Program or Provider
- Evaluate for disease management – MHP Follow-up

Asthma

- Member currently on prescribed steroid or leukotriene
- Received appropriate referral to Clinic or Provider - MHP Approved
- Asthma education
- Evaluate for referral to disease management – MHP follow-up

Cardiac

- Evidence that member is on a Beta Blocker on discharge if a myocardial infarction
- Chronic heart failure patients should be evaluated for appropriate home health services
- Evaluate for referral to disease management – MHP follow-up

Additional Testing Performed as In-Patient

- Tests were documented
- Abnormal results were addressed
- Evidence that member had a follow-up with MHP for abnormal results, or to obtain results with primary care physician